TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF PLANO

Respondent Name
TRUMBULL INSURANCE COMPANY

MFDR Tracking Number
M4-17-0316-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per fee schedule should pay per the APC allowable at 200% regardless of the billed charges"

Amount in Dispute: $36.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected by the attached EOBs, Trumbull reimbursed Texas Health in accordance with the Texas Workers' Compensation and applicable Division of Workers' Compensation rules. Texas Plano has failed to demonstrate how it is entitled to additional reimbursement."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2016	Outpatient Hospital Facility Services, Procedure Code 90471	$36.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier did not reduce payment for the disputed service, paying the billed amount in full, without comment, but indicating the following claim denial reason codes upon reconsideration of the bill:
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. [Note: no actual additional payment was made.]
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

- N00C – Internal Use Only
- 947 – UPHELD NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Upon initial payment, the insurance carrier did not reduce payment for disputed procedure code 90471 and paid the line item on the bill in full — without comment or reduction reason code indicated for this line on the explanation of benefits (EOB).

   After reconsideration, the insurance carrier issued a second EOB with payment denial explanation codes indicating that the original payment determination was maintained and upheld, and finding no additional allowance to be warranted.

   The requestor has disputed only one line item of the bill, stating that "Per Rule 134.403 section E all HCPC's that are paid per fee schedule should pay per the APC allowable at 200% regardless of the billed charges."

   28 Texas Administrative Code §134.403(e)(2) states that, regardless of billed amount, reimbursement shall be "the maximum allowable reimbursement (MAR) amount . . . "

   The health care provider billed $46.75 for this line item. The insurance carrier paid this line item in full; however, the requestor asserts the MAR is actually greater than the billed amount — so per the Rule, the insurance carrier should have paid *more* than the billed amount in order to reimburse the MAR.

   The response asserts that the insurance carrier reimbursed the health care provider "in accordance with the Texas Workers' Compensation and applicable Division of Workers' Compensation rules."

   As the insurance carrier does not dispute the requestor's entitlement to payment, and has not raised any defenses beyond that services were paid according to applicable division rules, the disputed services will be reviewed for payment in accordance with applicable division rules and fee guidelines.

   Although the requestor has disputed only one line item of the bill, the division's *Hospital Facility Fee Guideline—Outpatient*, which is based on Medicare's Outpatient Prospective Payment System (OPPS), requires that all the line items of the hospital bill be reviewed together, in context, to determine if the disputed line item was paid correctly — as payment for each line item may change depending on what other combinations of services and items were billed on the same claim.

2. Under OPPS, each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Pharmacy charges, billed under Revenue code 250, are packaged services; payment for these items is included with the payment for other facility services billed on the same date. (The division notes however that the insurance carrier paid $4.74 for this line item.)
   - Procedure code 73090 has status indicator Q1 denoting STVX-packaged codes; this code is separately payable only if no other procedures with status indicators of S, T, V, or X are reported for the same date. Payment for this x-ray exam service is packaged with the payment for other billed services performed on this date that have status indicators S and V (see below). Reimbursement is not recommended.

- Procedure codes 70450 and 70486 have status indicator Q3 denoting conditionally packaged codes paid through a composite APC. Services assigned to a composite APC are major components of a single episode of care; the hospital receives one payment under a composite APC for multiple separate major services. Reimbursement is packaged into a single payment for any combination of designated computed tomography (CT) services (without contrast) performed on the same date, These services are assigned to composite APC 8005 and assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. APC 8005 has a payment rate of $284.12 per OPPS Addendum A. This amount multiplied by 60% yields an unadjusted labor-related amount of $170.47, which is multiplied by the annual wage index for this facility of 0.9731, yielding an adjusted labor-related amount of $165.88. The non-labor related portion is 40% of the APC rate, or $113.65. The sum of the labor and non-labor related amounts is $279.53. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250; the outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $279.53. This amount multiplied by 200% gives a MAR of $559.06. (The division notes however that the insurance carrier paid a combined total $590.83 for these two line items, representing an overage of $31.77.)
- Evaluation and management service code 99284 is assigned status indicator V denoting an emergency care visit paid under OPPS with separate APC payment. This service is classified under APC 5024, which has a payment rate of $326.99 per OPPS Addendum A. This amount multiplied by 60% yields an unadjusted labor-related amount of $196.19. This amount multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor-related amount of $190.91. The non-labor related portion is 40% of the APC rate, or $130.80. The sum of the labor and non-labor related amounts is $321.71. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250; the outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $321.71. This amount multiplied by 200% yields a MAR of $643.42.
- Procedure code 90715 has status indicator N denoting packaged codes with no separate payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 90471 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This immunization service is classified under APC 5692, which has a payment rate of $42.31 per OPPS Addendum A. This amount multiplied by 60% yields an unadjusted labor-related amount of $25.39. This amount multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor-related amount of $24.71. The non-labor related portion is 40% of the APC rate or $16.92. The sum of the labor and non-labor related amounts is $41.63. The cost of these services does not exceed the annual fixed-dollar threshold of $3,250; the outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $41.63. This amount multiplied by 200% yields a MAR of $83.26.

3. The total recommended payment for the entire bill is $1,285.74. This amount less the amount previously paid by the insurance carrier of $1,285.74 leaves an amount due to the requestor of $0.00. The requestor is correct that the MAR for procedure code 90471 is $83.26 and that the insurance carrier only paid the billed amount of $46.75 — leaving a shortfall of $36.51 for that individual line item.

   However, the insurance carrier made up for the shortfall by apportioning the extra payment to other line items. The insurance carrier paid $4.74 for revenue code 250 and a combined overage of $31.77 for codes 70450 and 70486 (CT services that are paid together under a composite APC). The overage applied to these line items totals the missing $36.50 that the requestor is seeking. The MAR for the sum of all billed lines together totals $1,285.74, which is the precise amount the insurance carrier paid. Consequently, the division concludes the requestor is not entitled to any additional payment.

Conclusion

The insurance carrier paid the correct MAR for the entire bill, considered as a whole. Even though the disputed line item was underpaid, the missing payment for that line was applied to other billed lines on the same claim. The total payment sent to the provider for the bill was the correct amount due in accordance with division rules. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 3, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.